SENATE SUBSTITUTE

FOR

SENATE COMMITTEE SUBSTITUTE

FOR

HOUSE BILL NO. 1446

AN ACT

To repeal sections 33.103, 103.095, 194.220, 194.230, 354.085, 354.405, 354.603, 376.1209 and 376.1350, RSMo, and to enact in lieu thereof eighteen new sections relating to health insurance, with an effective date for a certain section.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF MISSOURI, AS FOLLOWS:

Section A. Sections 33.103, 103.095, 194.220, 194.230, 354.085, 354.405, 354.603, 376.1209 and 376.1350, RSMo, are repealed and eighteen new sections enacted in lieu thereof, to be known as sections 33.103, 33.900, 103.095, 194.220, 194.230, 354.085, 354.405, 354.407, 354.603, 376.429, 376.430, 376.1209, 376.1253, 376.1275, 376.1350, 376.1450, 376.1575 and 1, to read as follows:

33.103. 1. Whenever the employees of any state department, division or agency establish any voluntary retirement plan, or participate in any group hospital service plan, group life insurance plan, medical service plan or other such plan, or if they are members of an employee collective bargaining organization, or if they participate in a group plan for uniform rental, the commissioner of administration may deduct from such employees' compensation warrants the amount necessary for each employee's participation in the plan or collective bargaining

dues, provided that such dues deductions shall be made only from those individuals agreeing to such deductions. Before such deductions are made, the person in charge of the department, division or agency shall file with the commissioner of administration an authorization showing the names of participating employees, the amount to be deducted from each such employee's compensation, and the agent authorized to receive the deducted amounts. The amount deducted shall be paid to the authorized agent in the amount of the total deductions by a warrant issued as provided by law.

2. The commissioner of administration may, in the same manner, deduct from any state employee's compensation warrant:

(1) Any amount authorized by the employee for the purchase of shares in a state employees' credit union in Missouri;

(2) Any amount authorized by the employee for contribution to a fund resulting from a united, joint community-wide solicitation or to a fund resulting from a nationwide solicitation by charities rendering services or otherwise fulfilling charitable purposes if the fund is administered in a manner requiring public accountability and public participation in policy decisions;

(3) Any amount authorized by the employee for the payment of dues in an employee association;

(4) Any amount determined to be owed by the employee to the state in accordance with guidelines established by the commissioner of administration which shall include notice to the employee and an appeal process;

(5) Any amount voluntarily assigned by the employee for

payment of child support obligations determined pursuant to chapter 452 or 454, RSMo; and

(6) Any amount authorized by the employee for contributions to any "qualified state tuition program" pursuant to Section 529 of the Internal Revenue Code of 1986, as amended, sponsored by the state of Missouri.

3. The commissioner of administration may establish a cafeteria plan in accordance with Section 125 of Title 26 United States Code for state employees. The commissioner of administration must file a written plan document to be filed in accordance with chapter 536, RSMo. Employees must be furnished with a summary plan description one hundred twenty days prior to the effective date of the plan. In connection with such plans, the commissioner **[**may**]** shall:

(1) Include as an option in the plan any employee benefit, otherwise available to state employees, administered by a statutorily created retirement system;

(2) Provide and administer, or select companies on the basis of competitive bids or proposals to provide or administer, any group insurance, or other plan which may be included as part of a cafeteria plan, provided such plan is not duplicative of any other plan, otherwise available to state employees, administered by a statutorily created retirement system; **[**and**]**

(3) Include products from vendors if the product is eligible under Section 125 of Title 26 of the United States Code, the vendor is approved by the office of administration to provide benefits on a payroll-deduction basis, and the vendor is receiving in excess of five hundred thousand dollars annually

from state employees through voluntary payroll deductions; and

(4) Reduce each participating employee's compensation warrant by the amount necessary for each employee's participation in the cafeteria plan, provided that such salary reduction shall be made only with respect to those individuals agreeing to such reduction. No such reduction in salary for the purpose of participation in a cafeteria plan shall have the effect of reducing the compensation amount used in calculating the state employee's retirement benefit under a statutorily created retirement system or reducing the compensation amount used in calculating the state employee's compensation or wages for purposes of any workers' compensation claim governed by chapter 287, RSMo.

4. Employees may authorize deductions as provided in this section in writing or by electronic enrollment.

33.900. 1. As used in this section, the following words and phrases shall mean:

(1) "Abortion services", shall include performing, inducing or assisting with abortions as defined in section 188.015, RSMo, or encouraging patients to have abortions, or referring patients for abortions, not necessary to save the life of the mother; or development of drugs, chemicals or devices intended to be used to induce an abortion;

(2) "Child", if in vivo, an unborn child as defined in section 188.015, RSMo, and if in vitro, a human being at any of the stages of biological development of an unborn child from conception or inception onward;

(3) "Conception", as defined in section 188.015, RSMo;

(4) "Facilities and administrative costs", those costs that are incurred for common or joint objectives and therefore cannot be identified readily and specifically with a particular research project or any other institutional activity;

(5) "Health and social services program", any activity, program or the furnishing of services for the purpose of preventing, supporting, alleviating, ameliorating, treating, curing or healing any human physical condition, illness, injury or disability, or to safeguard the health of people and ensure the prevention of any type of physical condition, disease, infection or injury, the promotion of specific lifestyle, hygiene and sanitary conditions, or to assist persons to provide for themselves and others and to assist those experiencing any social or physical condition or disadvantage; and including the furnishing of any sort of physical, health, medical or dental assessment, care, counseling, education or treatment, whether to individuals or groups of individuals; but shall not include a research project;

(6) "Human cloning", genetic duplication or replication of a human being, whether living or deceased, regardless of the stage of development of such human being, from whom genetic material was donated or taken in order to complete such duplication or replication;

(7) "Independent affiliate", an entity that provides abortion services that is affiliated with an entity that does not provide abortion services; which is separately incorporated from the entity that does not provide abortion services; that does not receive or share a direct or indirect economic or marketing

benefit from such affiliation with the entity that does not provide abortion services; and which does not share any of the following with the entity that does not provide abortion services, regardless of whether or not reimbursement is made for any expenditures associated with sharing the following:

(a) The same name or similar names;

(b) Medical or non-medical facilities, including but not limited to business offices; laboratories; treatment, consultation, examination and waiting rooms;

(c) Expenses;

(d) Employee wages or salaries; or

(e) Equipment or supplies, including but not limited to computers, telephone systems, telecommunications equipment, and office and medical supplies;

(8) "Nondirective pregnancy counseling", counseling related to pregnancy that does not include abortion services, but may include providing patients with information regarding providers of health care and social service programs that provide pregnancy, prenatal, delivery, infant care, foster care, adoption, and alternative to abortion services. Such information may categorize the providers by the service or services they provide;

(9) "Prohibited human research", research in a research project in which there is the taking or utilization of the organs, tissue or cellular material of a:

(a) Deceased child, unless consent is given by the parents in the manner provided in sections 194.210 to 194.290, RSMo, relating to anatomical gifts, and neither parent caused the death

of such child or consented to another person causing the death of such child;

(b) Living child, when the intended or likely result of such taking or utilization is to kill or cause harm to the health, safety or welfare of such child, or when the purpose is to target such child for possible destruction in the future;

(10) "Public funds", shall include:

(a) Any funds received or controlled by the state of Missouri or any official, department, division, agency or political subdivision thereof, including, but not limited to, funds derived from federal, state or local taxes, gifts or grants from any source, settlements of any claims or causes of action, public or private, bond proceeds, federal grants or payments, or intergovernmental transfers;

(b) Any funds received or controlled by any official, department, division or agency of state government or political subdivision thereof, or to any other person or entity, pursuant to appropriation by the general assembly or the governing body of any political subdivision of this state;

(11) "Research project", research specified in an award of public funds conducted under the auspices of the entity or entities that applied for and received such award, regardless of whether the research is funded in whole or part by such award. Such research shall include basic research, including the discovery of new knowledge; translational research, including translating knowledge into a usable form; and developmental research and clinical research, including but not limited to health research in human development and aging, cancer,

endocrine, cardiovascular, neurological, pulmonary and infectious disease.

2. Public funds shall not be expended, paid or granted to or on behalf of an existing or proposed health and social services program to directly or indirectly subsidize abortion services. In order to ensure that support is not lent in any manner to abortion services, and to ensure that an entity that provides abortion services does not receive a direct or indirect economic or marketing benefit from public funds expended in connection with any health and social services program:

(1) Public funds shall not be expended, paid or granted in connection with any health and social services program to an entity that provides abortion services;

(2) An entity that does not provide abortion services may receive public funds in connection with any health and social services program if affiliated with an entity that provides abortion services, only if the affiliated entity that provides abortion services is an independent affiliate;

(3) An entity that provides counseling to pregnant persons in connection with a health and social services program receiving public funds shall only provide nondirective pregnancy counseling;

(4) An entity that receives public funds in connection with any health and social services program shall not display or distribute marketing materials promoting abortion services;

(5) An entity that receives public funds in connection with any health and social services program must maintain financial records that demonstrate strict compliance with this subsection;

(6) An independent audit of any entity that receives public funds in connection with any health and social services program shall be conducted at least once every three years, or sooner if required by any other provision of law or if directed by the governmental entity expending, paying or granting the public funds, to ensure compliance with this subsection. If the recipient of the public funds is an affiliate of an entity that provides abortion services, an independent audit to ensure compliance with this subsection shall be conducted at least annually. The audit shall be conducted by the state auditor if allowed by law, or by either an independent auditing firm retained by the governmental entity expending, paying or granting the public funds or by an independent auditing firm approved by the governmental entity expending, paying or granting the public funds and retained by the entity receiving public funds.

3. Any entity eligible to receive reimbursements pursuant to Title XIX of the federal Social Security Act (42 U.S.C. section 1396, et seq.) may be reimbursed for services it has performed, for which the payment to such entity is otherwise prohibited pursuant to subsection 2 of this section, provided that reimbursement for such services is required under the federal act and the refusal to reimburse for such required services will result in the withholding of federal Medicaid funds to the state of Missouri.

4. Restrictions of specific applicability contained in the statutes of this state regarding the use of public funds for abortion services shall take precedence over the restrictions of general applicability contained in subsection 2 of this section

and sections 188.200 to 188.220, RSMo.

5. Public funds shall not be expended, paid or granted to or on behalf of an existing or proposed research project that involves abortion services, human cloning or prohibited human research. A research project that receives an award of public funds shall not share costs with another research project, person or entity not eligible to receive public funds pursuant to this subsection; provided, however, the research project that receives an award of public funds may pay facilities and administrative costs directly allocable to such research project. A research project that receives an award of public funds shall maintain financial records that demonstrate strict compliance with this subsection. Any audit conducted pursuant to the provisions of any grant or contract awarding public funds shall also certify compliance with this subsection.

6. The provisions of this section shall inure to the benefit of all residents of this state. Any taxpayer of this state or its political subdivisions shall have standing to bring suit against the state of Missouri or any official, department, division, agency or political subdivision of the state, and any recipient of public funds, who or which is in violation of this section, in any circuit court with jurisdiction to enforce the provisions of this section.

7. This section shall not be construed to permit or make lawful any conduct that is otherwise unlawful pursuant to the laws of this state.

8. Any provision of this section is not severable from any appropriation subject to this section or any appropriation

declared by any court to be subject to this section. If any provision of this section is found to be invalid, unenforceable or unconstitutional, then any appropriation subject to this section or any appropriation declared by any court to be subject to this section shall be void, invalid and unenforceable.

103.095. 1. Notwithstanding any other provision of law to the contrary, any member of the general assembly and any elected state official holding a statewide elective state office, who ceases to hold elective office, or any person employed by the elected official or employed by a member of the general assembly, whose employment is terminated because such elected official or member of the general assembly ceases to hold elective office, may elect to continue insurance benefits to cover medical expenses provided under sections 103.003 to 103.175, by paying the cost of such benefits **[**as determined by the board**]** in an amount equal to the total premium cost of such benefit at the rate established for current members of the general assembly, elected state officials, and employees of the general assembly. Except as otherwise provided for in subsection 2 of this section, if an eligible person does not elect to continue the coverage within thirty-one days from the last day of the month in which the eligible person ceases to be an employee, he or she may not later elect to be covered under this section.

2. Any former member of the general assembly, former elected state official who held a statewide elective state office, or any person formerly employed by an elected official or a member of the general assembly who was terminated prior to the effective date of this section and was eligible for insurance

benefits through the state of Missouri at the time of his or her employment with the state Missouri may purchase insurance benefits in accordance with subsection 1 of this section by electing such coverage within six months of the effective date of this section.

194.220. 1. Any individual of sound mind who is at least eighteen years of age may give all or any part of his or her body for any purpose specified in section 194.230, the gift to take effect upon death. Any individual who is a minor and at least sixteen years of age may effectuate a gift for any purpose specified in section 194.230, provided parental or guardian consent is deemed given. Parental or guardian consent shall be noted on the minor's donor card, application for the donor's instruction permit or driver's license, or other document of gift. An express gift that is not revoked by the donor before death is irrevocable, and the donee shall be authorized to accept the gift without obtaining the consent of any other person.

2. Any of the following persons, in order of priority stated, when persons in prior classes are not available at the time of death, and in the absence of actual knowledge of a gift by the decedent [under] pursuant to subsection 1 of this section or actual notice of contrary indications by the decedent [or of opposition by a member of the same or a prior class], may give all or any part of the decedent's body for any purpose specified in section 194.230:

(1) An attorney in fact under a durable power of attorney that expressly refers to making a gift of all or part of the principal's body [under] pursuant to the uniform anatomical gift

act;

(2) The spouse;

(3) An adult son or daughter;

(4) Either parent;

(5) An adult brother or sister;

(6) A guardian of the person of the decedent at the time of his or her death;

(7) Any other person authorized or under obligation to dispose of the body.

3. If the donee has actual notice of contrary indications by the decedent [or that a gift by a member of a class is opposed by a member of the same or a prior class], the donee shall not accept the gift. The persons authorized by subsection 2 of this section may make the gift after or immediately before death.

4. A gift of all or part of a body authorizes any examination necessary to assure medical acceptability of the gift for the purposes intended.

5. The rights of the donee created by the gift are paramount to the rights of others except as provided by subsection 4 of section 194.270.

194.230. The following persons may become donees of gifts of bodies or parts thereof for the purposes stated:

(1) Any hospital, surgeon, or physician, for medical or dental education, research, advancement of medical or dental science, therapy, or transplantation; or

(2) Any accredited medical or dental school, college or university or the state anatomical board for education, research, advancement of medical or dental science, or therapy; or

(3) Any bank or storage facility, for medical or dental education, research, advancement of medical or dental science, therapy, or transplantation; or

(4) Any specified individual for therapy or transplantation needed by [him] such individual.

354.085. No corporation subject to the provisions of sections 354.010 to 354.380 shall deliver or issue for delivery in this state a form of membership contract, or any endorsement or rider thereto, until a copy of the form shall have been approved by the director. The director shall not approve any policy forms which are not in compliance with the provisions of sections 354.010 to 354.380 of this state, or which contain any provision which is deceptive, ambiguous or misleading, or which do not contain such words, phraseology, conditions and provisions which are specific, certain and reasonably adequate to meet needed requirements for the protection of those insured. If a policy form is disapproved, the reasons therefor shall be stated in writing; a hearing shall be granted upon such disapproval, if so requested; provided, however, that such hearing shall be held no sooner than fifteen days following the request. The failure of the director of insurance to take action approving or disapproving a submitted policy form within [thirty] forty-five days from the date of filing shall be deemed an approval thereof [until such time as the director of insurance shall notify the submitting company, in writing, of his disapproval]. The director may not disapprove any deemed policy form for a period of twelve months thereafter. If at any time during such twelve-month period the director determines that any provision of the

deemed policy form is contrary to statute, the director shall notify the health services corporation of the specific provision that is contrary to statute, and the specific statute to which the provision is contrary to, and may request, if the director determines it to be necessary and appropriate, that the health services corporation file within thirty days of receipt of the request an amendment form that modifies the provision to conform to statute. Upon approval of the amendment form by the director, the health services corporation shall issue a copy of the amendment to each individual and entity to which the deemed policy form was previously issued and shall attach a copy of the amendment to the deemed policy form when it is subsequently issued. Such amendment shall have the force and effect as if the amendment was in the original filing or policy. If the deemed policy form is a certificate or other form issued to individual members, the health services corporation may fulfill its obligation to issue the conforming amendment to members to whom the deemed policy form was previously issued by either:

(1) For group coverage, supplying the group contract holder with a sufficient number of copies of the amendment so that the group contract holder may distribute a copy to each member to whom the deemed policy form was previously issued; or

(2) For group or individual coverage, including a copy of the amendment or a description of its contents in the health services corporation's next scheduled mailing to members.

The director of insurance shall have authority to make such reasonable rules and regulations concerning the filing and submission of such policy forms as are necessary, proper or

advisable.

354.405. 1. Notwithstanding any law of this state to the contrary, any person may apply to the director for a certificate of authority to establish and operate a health maintenance organization in compliance with this act. No person shall establish or operate a health maintenance organization in this state without obtaining a certificate of authority pursuant to sections 354.400 to 354.636. A foreign corporation may qualify pursuant to sections 354.400 to 354.636, subject to its registration to do business in this state as a foreign corporation pursuant to chapter 351, RSMo, and compliance with the provisions of sections 354.400 to 354.636.

2. Every health maintenance organization doing business in this state on September 28, 1983, shall submit an application for a certificate of authority pursuant to subsection 3 of this section within one hundred twenty days of September 28, 1983. Each such applicant may continue to operate until the director acts upon the application. In the event that an application is not submitted or is denied pursuant to section 354.410, the applicant shall henceforth be treated as a health maintenance organization whose certificate of authority has been revoked. Any health maintenance organization licensed by the department of insurance prior to September 28, 1983, and complying with the paid-in capital or guarantee fund requirements of section 354.410 shall be issued a certificate of authority upon filing an amended certificate of authority and an amended articles of incorporation that conform with sections 354.400 to 354.636. When the annual statement of a health maintenance organization subject to the

provisions of sections 354.400 to 354.636 is filed and all fees due from the health maintenance organization are tendered, the health maintenance organization's certificate of authority to do business in this state shall automatically be extended pending formal renewal by the director, or until such time as the director should refuse to renew the certificate.

3. Each application for a certificate of authority shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the director, and shall set forth or be accompanied by the following:

(1) A copy of the organizational documents of the applicant such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto;

(2) A copy of the bylaws, rules and regulations, or similar document, if any, regulating the conduct of the internal affairs of the applicant;

(3) A list of the names, addresses, and official positions of the persons who are to be responsible for the conduct of the affairs of the applicant, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers if the applicant is a corporation, and the partners or members if the applicant is a partnership or association;

(4) A copy of any contract made or to be made between any providers and persons listed in subdivision (3) of this subsection and the applicant;

(5) A copy of the form of evidence of coverage to be issued

to the enrollees;

(6) A copy of the form of the group contract, if any, which is to be issued to employers, unions, trustees, or other organizations;

(7) Financial statements showing the applicant's assets, liabilities, and sources of financial support. If the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent certified financial statement shall be deemed to satisfy this requirement unless the director directs that additional or more recent financial information is required for the proper administration of sections 354.400 to 354.636;

(8) A description of the proposed method of marketing the plan, a financial plan which includes a three-year projection of operating results anticipated, and a statement as to the sources of working capital as well as any other sources of funding;

(9) If the applicant is not domiciled in this state, a power of attorney duly executed by such applicant appointing the director, the director's successors in office, and duly authorized deputies, as the true and lawful attorney of such applicant in and for this state upon whom all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in this state may be served;

(10) A statement reasonably describing the geographic area or areas to be served;

(11) A description of the complaints procedures to be utilized as required by section 354.445;

(12) A description of the mechanism by which enrollees will be afforded an opportunity to participate in matters of policy and operation;

(13) Evidence demonstrating that the health maintenance organization has provided its enrollees with adequate access to health care providers; and

(14) Such other information as the director may require to make the determinations required in section 354.410.

4. Every health maintenance organization shall file with the director notice of its intention to modify any of the procedures or information described in and required to be filed by this section. Such changes shall be filed with the director prior to the actual modification. If a filing that is a document described in subdivision (4), (5), or (6) of subsection 3 of this section is disapproved, the reasons therefor shall be stated in writing and a hearing shall be granted upon such disapproval if so requested; provided that such hearing shall be held no sooner than fifteen days following the request. If the director does not approve or disapprove the modification within **[**thirty**]** forty-five days of filing, such modification shall be deemed approved. If a filing that is deemed approved is a document described in subdivision (4), (5) or (6) of subsection 3 of this section, the director may not disapprove the deemed filing for a period of twelve months thereafter. If at any time during that twelve-month period the director determines that any provision of the deemed filing is contrary to statute, the director shall notify the health maintenance organization of the specific provision that is contrary to statute, and the specific statute to which

the provision is contrary to, and may request, if the director determines it to be necessary and appropriate, that the health maintenance organization file within thirty days of receipt of the request an amendment form that modifies the provision to conform to the state statute. Upon approval of the amendment form by the director, the health maintenance organization shall issue a copy of the amendment to each individual and entity to which the deemed filing was previously issued and shall attach a copy of the amendment to the deemed filing when it is subsequently issued. Such amendment shall have the force and effect as if the amendment was in the original filing or policy. If the deemed policy form is an evidence of coverage or other form issued to individual enrollees, the health maintenance organization may fulfill its obligation to issue the conforming amendment to enrollees to whom the deemed policy form was previously issued by either:

(1) For group coverage, supplying the group contract holder with a sufficient number of copies of the amendment so that the group contract holder may distribute a copy to each enrollee to whom the deemed policy form was previously issued; or

(2) For group or individual coverage, including a copy of the amendment or a description of its contents in the health maintenance organization's next scheduled mailing to enrollees.

5. A health maintenance organization shall file all contracts of reinsurance. Any agreement between the organization and an insurer shall be subject to the laws of this state regarding reinsurance. All reinsurance agreements and any modifications thereto shall be filed and approved.

6. When the director deems it appropriate, the director may exempt any item from the filing requirements of this section.

354.407. Notwithstanding the provisions of section 354.405 to the contrary, a program for all-inclusive care for the elderly (PACE) project sponsored by a religious or charitable organization that is itself or is controlled by an entity organized under Section 501(c)(3) of the Internal Revenue Code and which has had its application for the operation of a PACE program approved by the Center for Medicare and Medicaid Services of the federal Department of Health and Human Services and is operating under such approval shall not be deemed to be engaged in any business required to be licensed pursuant to section 354.405. Such exemption shall apply only to business conducted pursuant to the approved PACE contract and not to any other business that such organization may conduct.

354.603. 1. A health carrier shall maintain a network that is sufficient in number and types of providers to assure that all services to enrollees shall be accessible without unreasonable delay. In the case of emergency services, enrollees shall have access twenty-four hours per day, seven days per week. The health carrier's medical director shall be responsible for the sufficiency and supervision of the health carrier's network. Sufficiency shall be determined by the director in accordance with the requirements of this section and by reference to any reasonable criteria, including but not limited to, provider-enrollee ratios by specialty, primary care provider-enrollee ratios, geographic accessibility, reasonable distance accessibility criteria for pharmacy and other services,

waiting times for appointments with participating providers, hours of operation, and the volume of technological and specialty services available to serve the needs of enrollees requiring technologically advanced or specialty care.

(1) In any case where the health carrier has an insufficient number or type of participating providers to provide a covered benefit, the health carrier shall ensure that the enrollee obtains the covered benefit at no greater cost than if the benefit was obtained from a participating provider, or shall make other arrangements acceptable to the director.

(2) The health carrier shall establish and maintain adequate arrangements to ensure reasonable proximity of participating providers, including local pharmacists, to the business or personal residence of enrollees. In determining whether a health carrier has complied with this provision, the director shall give due consideration to the relative availability of health care providers in the service area under, especially rural areas, consideration.

(3) A health carrier shall monitor, on an ongoing basis, the ability, clinical capacity, and legal authority of its providers to furnish all contracted benefits to enrollees. The provisions of this subdivision shall not be construed to require any health care provider to submit copies of such health care provider's income tax returns to a health carrier. A health carrier may require a health care provider to obtain audited financial statements if such health care provider received ten percent or more of the total medical expenditures made by the health carrier.

(4) A health carrier shall make its entire network available to all enrollees unless a contract holder has agreed in writing to a different or reduced network.

2. A health carrier shall file with the director, in a manner and form defined by rule of the department of insurance, an access plan meeting the requirements of sections 354.600 to 354.636 for each of the managed care plans that the health carrier offers in this state. The health carrier may request the director to deem sections of the access plan as proprietary or competitive information that shall not be made public. For the purposes of this section, information is proprietary or competitive if revealing the information will cause the health carrier's competitors to obtain valuable business information. The health carrier shall provide such plans, absent any information deemed by the director to be proprietary, to any interested party upon request. The health carrier shall prepare an access plan prior to offering a new managed care plan, and shall update an existing access plan whenever it makes any change as defined by the director to an existing managed care plan. The director shall approve or disapprove the access plan, or any subsequent alterations to the access plan, within sixty days of filing. The access plan shall describe or contain at a minimum the following:

(1) The health carrier's network;

(2) The health carrier's procedures for making referrals within and outside its network;

(3) The health carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to

meet the health care needs of enrollees of the managed care plan;

(4) The health carrier's methods for assessing the health care needs of enrollees and their satisfaction with services;

(5) The health carrier's method of informing enrollees of the plan's services and features, including but not limited to, the plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care;

(6) The health carrier's system for ensuring the coordination and continuity of care for enrollees referred to specialty physicians, for enrollees using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

(7) The health carrier's process for enabling enrollees to change primary care professionals;

(8) The health carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers, in the event of a reduction in service area or in the event of the health carrier's insolvency or other inability to continue operations. The description shall explain how enrollees shall be notified of the contract termination, reduction in service area or the health carrier's insolvency or other modification or cessation of operations, and transferred to other health care professionals in a timely manner; and

(9) Any other information required by the director to determine compliance with the provisions of sections 354.600 to 354.636.

3. In reviewing an access plan filed pursuant to subsection 2 of this section, the director shall deem a managed care plan's network to be adequate if, in lieu of the network information required by subdivision (1) of subsection 2 of this section, the health carrier submits a sworn affidavit signed by an officer of the health carrier stating that it meets one or more of the following criteria:

(1) The managed care plan is a Medicare + Choice coordinated care plan offered by the health carrier pursuant to a contract with the Federal Centers for Medicare and Medicaid Services;

(2) The managed care plan is being offered by a health carrier that has been accredited by the National Committee for Quality Assurance at a level of "accredited" or better, and such accreditation is in effect at the time the access plan is filed;

(3) The managed care plan's network has been accredited by the Joint Commission on the Accreditation of Health Organizations at a level of "accreditation without type I recommendations" or better, and such accreditation is in effect at the time the access plan is filed. If the accreditation applies to only a portion of the managed care plan's network, only the accredited portion will be deemed adequate; or

(4) The managed care plan network is accredited by any other accrediting organization that is approved by the Missouri department of insurance.

376.429. 1. All health benefit plans, as defined in section 376.1350, that are delivered, issued for delivery, continued or renewed on or after August 28, 2002, and providing

coverage to any resident of this state shall provide coverage for routine patient care costs as defined in subsection 6 of this section incurred as the result of phase III or IV of a clinical trial that is approved by an entity listed in subsection 4 of this section and is undertaken for the purposes of the prevention, early detection, or treatment of cancer.

2. In the case of treatment under a clinical trial, the treating facility and personnel must have the expertise and training to provide the treatment and treat a sufficient volume of patients. There must be equal to or superior, noninvestigational treatment alternatives and the available clinical or preclinical data must provide a reasonable expectation that the treatment will be superior to the noninvestigational alternatives.

3. Coverage required by this section shall include coverage for routine patient care costs incurred for drugs and devices that have been approved for sale by the Food and Drug Administration (FDA), regardless of whether approved by the FDA for use in treating the patient's particular condition, including coverage for reasonable and medically necessary services needed to administer the drug or use the device under evaluation in the clinical trial.

4. Subsections 1 and 2 of this section requiring coverage for routine patient care costs shall apply to clinical trials that are approved or funded by one of the following entities:

(1) One of the National Institutes of Health (NIH);

(2) An NIH Cooperative Group or Center as defined in subsection 7 of this section;

(3) The FDA in the form of an investigational new drug application;

(4) The federal Departments of Veterans' Affairs or Defense;

(5) An institutional review board in this state that has an appropriate assurance approved by the Department of Health and Human Services assuring compliance with and implementation of regulations for the protection of human subjects (45 CFR 46); or

(6) A qualified research entity that meets the criteria for NIH Center support grant eligibility.

5. An entity seeking coverage for treatment, prevention, or early detection in a clinical trial approved by an institutional review board under subdivision (5) of subsection 4 of this section shall maintain and post electronically a list of the clinical trials meeting the requirements of subsections 2 and 3 of this section. This list shall include: the phase for which the clinical trial is approved; the entity approving the trial; whether the trial is for the treatment of cancer or other serious or life threatening disease, and if not cancer, the particular disease; and the number of participants in the trial. If the electronic posting is not practical, the entity seeking coverage shall periodically provide payers and providers in the state with a written list of trials providing the information required in this section.

6. As used in this section, the following terms shall mean:

(1) "Cooperative group", a formal network of facilities that collaborate on research projects and have an established NIH-approved Peer Review Program operating within the group,

including the NCI Clinical Cooperative Group and the NCI Community Clinical Oncology Program;

(2) "Multiple project assurance contract", a contract between an institution and the federal Department of Health and Human Services (DHHS) that defines the relationship of the institution to the DHHS and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects;

(3) "Routine patient care costs", shall include coverage for reasonable and medically necessary services needed to administer the drug or device under evaluation in the clinical trial. Routine patient care costs include all items and services that are otherwise generally available to a qualified individual that are provided in the clinical trial except:

(a) The investigational item or service itself;

(b) Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and

(c) Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

7. For the purpose of this section, providers participating in clinical trials shall obtain a patient's informed consent for participation on the clinical trial in a manner that is consistent with current legal and ethical standards. Such documents shall be made available to the health insurer upon request.

8. The provisions of this section shall not apply to a policy, plan or contract paid under Title XVIII or Title XIX of

the Social Security Act.

376.430. 1. Any health benefit plan, as defined in section 376.1350, that provides coverage for prescription drugs or devices and that issues, uses or requires, a card or other technology for prescription claims submission and adjudication, and third-party administrators for self-insured plans, and state-administered plans, or the plan's agents or contractors that issue such cards or other technology, shall issue for the plan's insureds, enrollees, or participants, a uniform prescription drug information card or other technology that conforms to the standards and format of the current National Council for Prescription Drug Programs (NCPDP) Pharmacy ID Card Implementation Guide. Such cards or other technology shall include all of the NCPDP standard information required by the plan for submission and adjudication of claims for prescription drug or device benefits. If the prescription information is contained on the plan's standard member identification card, the card shall contain, at a minimum the name and phone number of the benefits administrator or other entity responsible for prescription claims submission, adjudication or pharmacy provider correspondence for prescription benefits claims.

2. The provisions of this section shall become effective January 1, 2003, and shall apply to health benefit plans that are delivered or issued for delivery. The provisions of this section shall also apply to all health benefit plans which make changes in prescription drug coverage.

376.1209. 1. Each entity offering individual and group health insurance policies providing coverage on an

expense-incurred basis, individual and group service or indemnity type contracts issued by a nonprofit corporation, individual and group service contracts issued by a health maintenance organization, all self-insured group arrangements to the extent not preempted by federal law, and all managed health care delivery entities of any type or description, that provide coverage for the surgical procedure known as a mastectomy, and which are delivered, issued for delivery, continued or renewed in this state on or after January 1, 1998, shall provide coverage for prosthetic devices or reconstructive surgery necessary to restore symmetry as recommended by the oncologist or primary care physician for the patient incident to the mastectomy. Coverage for prosthetic devices and reconstructive surgery shall be subject to the same deductible and coinsurance conditions applied to the mastectomy and all other terms and conditions applicable to other benefits with the exception that no time limit shall be imposed on an individual for the receipt of prosthetic devices or reconstructive surgery and if such individual changes his or her insurer, then the new policy subject to the federal Women's Health and Cancer Rights Act (Sections 901-903 of P.L. 105-277), as amended, shall provide coverage consistent with the federal Women's Health and Cancer Rights Act (Sections 901-903 of P.L. 105-277), as amended, and any regulations promulgated pursuant to such act. Such benefits shall include coverage for the purchase of at least four mastectomy brasseries a year.

2. As used in this section, the term "mastectomy" means the removal of all or part of the breast for medically necessary reasons, as determined by a physician licensed pursuant to

chapter 334, RSMo.

3. The provisions of this section shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy or long-term care policy.

376.1253. 1. Each physician attending any patient with a newly diagnosed cancer shall provide the patient with a timely referral to an appropriate specialist within the provider network for a second opinion regarding the treatment of the patient's type of cancer. If no specialist in that specific cancer diagnosis area is in the provider network, a referral shall be made to a nonnetwork specialist in accordance with this section.

2. Each health carrier or health benefit plan, as defined in section 376.1350, that offers or issues health benefit plans which are delivered, issued for delivery, continued or renewed in this state on or after January 1, 2003, shall provide coverage for a second opinion rendered by a specialist in that specific cancer diagnosis area when a patient with a newly diagnosed cancer is referred to such specialist by his or her attending physician. Such coverage shall be subject to the same deductible and coinsurance conditions applied to other specialist referrals and all other terms and conditions applicable to other benefits, including the prior authorization and/or referral authorization requirements as specified in the applicable health insurance policy.

3. The provisions of this section shall not apply to a supplemental insurance policy, including a life care contract,

accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, short-term major medical policies of six months or less duration, or any other supplemental policy as determined by the director of the department of insurance.

376.1275. 1. Each health carrier or health benefit plan that offers or issues health benefit plans which are delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2003, shall include coverage for the cost for human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for A, B, and DR antigens for utilization in bone marrow transplantation. The testing must be performed in a facility which is accredited by the American Association of Blood Banks or its successors, and is licensed under the Clinical Laboratory Improvement Act, 42 U.S.C. Section 263a, as amended. At the time of testing, the person being tested must complete and sign an informed consent from which also authorizes the results of the test to be used for participation in the National Marrow Donor Program. The health benefit plan may limit each enrollee to one such testing per lifetime not to exceed seventy-five dollars to be reimbursed by the health carrier or health benefit plan.

2. For the purposes of this section, "health carrier" and "health benefit plan" shall have the same meaning as defined in section 376.1350.

3. The health care service required by this section shall not be subject to any greater deductible or copayment than other similar health care services provided by the health benefit plan.

4. The provisions of this section shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, short-term major medical policies of six months or less duration, or any other supplemental policy as determined by the director of the department of insurance.

376.1350. For purposes of sections 376.1350 to [376.1390] 376.1393, the following terms mean:

(1) "Adverse determination", a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the payment for the requested service is therefore denied, reduced or terminated;

(2) "Ambulatory review", utilization review of health care services performed or provided in an outpatient setting;

(3) "Case management", a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions;

(4) "Certification", a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed and, based on the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care

and effectiveness;

(5) "Clinical peer", a physician or other health care professional who holds a nonrestricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review;

(6) "Clinical review criteria", the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by the health carrier to determine the necessity and appropriateness of health care services;

(7) "Concurrent review", utilization review conducted during a patient's hospital stay or course of treatment;

(8) "Covered benefit" or "benefit", a health care service that an enrollee is entitled under the terms of a health benefit plan;

(9) "Director", the director of the department of insurance;

(10) "Discharge planning", the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility;

(11) "Drug", any substance prescribed by a licensed health care provider acting within the scope of the provider's license and that is intended for use in the diagnosis, mitigation, treatment or prevention of disease. The term includes only those substances that are approved by the FDA for at least one indication;

(12) "Emergency medical condition", the sudden and, at the

time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but shall not be limited to:

(a) Placing the person's health in significant jeopardy;

(b) Serious impairment to a bodily function;

(c) Serious dysfunction of any bodily organ or part;

(d) Inadequately controlled pain; or

(e) With respect to a pregnant woman who is having contractions:

a. That there is inadequate time to effect a safe transfer to another hospital before delivery; or

b. That transfer to another hospital may pose a threat to the health or safety of the woman or unborn child;

(13) "Emergency service", a health care item or service furnished or required to evaluate and treat an emergency medical condition, which may include, but shall not be limited to, health care services that are provided in a licensed hospital's emergency facility by an appropriate provider;

(14) "Enrollee", a policyholder, subscriber, covered person or other individual participating in a health benefit plan;

(15) "FDA", the federal Food and Drug Administration;

(16) "Facility", an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging

centers, and rehabilitation and other therapeutic health settings;

(17) "Grievance", a written complaint submitted by or on behalf of an enrollee regarding the:

(a) Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

(b) Claims payment, handling or reimbursement for health care services; or

(c) Matters pertaining to the contractual relationship between an enrollee and a health carrier;

(18) "Health benefit plan", a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services<u>; except that, health benefit plan shall not include any coverage pursuant to liability insurance policy, workers' compensation insurance policy, or medical payments insurance issued as a supplement to a liability policy</u>;

(19) "Health care professional", a physician or other health care practitioner licensed, accredited or certified by the state of Missouri to perform specified health services consistent with state law;

(20) "Health care provider" or "provider", a health care professional or a facility;

(21) "Health care service", a service for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease;

(22) "Health carrier", an entity subject to the insurance laws and regulations of this state that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services; except that such plan shall not include any coverage pursuant to a liability insurance policy, workers' compensation insurance policy, or medical payments insurance issued as a supplement to a liability policy;

(23) "Health indemnity plan", a health benefit plan that is not a managed care plan;

(24) "Managed care plan", a health benefit plan that either requires an enrollee to use, or creates incentives, including financial incentives, for an enrollee to use, health care providers managed, owned, under contract with or employed by the health carrier;

(25) "Participating provider", a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than coinsurance, co-payments or deductibles, directly or indirectly from the health carrier;

(26) "Peer-reviewed medical literature", a published scientific study in a journal or other publication in which original manuscripts have been published only after having been

critically reviewed for scientific accuracy, validity and reliability by unbiased independent experts, and that has been determined by the International Committee of Medical Journal Editors to have met the uniform requirements for manuscripts submitted to biomedical journals or is published in a journal specified by the United States Department of Health and Human Services pursuant to section 1861(t)(2)(B) of the Social Security Act, as amended, as acceptable peer-reviewed medical literature. Peer-reviewed medical literature shall not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier;

(27) "Person", an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing;

(28) "Prospective review", utilization review conducted prior to an admission or a course of treatment;

(29) "Retrospective review", utilization review of medical necessity that is conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment;

(30) "Second opinion", an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health service to assess the clinical necessity and appropriateness of the initial proposed health service;

(31) "Stabilize", with respect to an emergency medical condition, that no material deterioration of the condition is likely to result or occur before an individual may be transferred;

(32) "Standard reference compendia":

(a) The American Hospital Formulary Service-Drug Information; or

(b) The United States Pharmacopoeia-Drug Information;

(33) "Utilization review", a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review. Utilization review shall not include elective requests for clarification of coverage;

(34) "Utilization review organization", a utilization review agent as defined in section 374.500, RSMo.

376.1450. An enrollee, as defined in section 376.1350, may waive his or her right to receive documents and materials from a managed care entity in printed form so long as such documents and materials are readily accessible electronically through the entity's Internet site. An enrollee may revoke such waiver at any time by notifying the managed care entity by phone or in writing. Any enrollee who does not execute such a waiver and prospective enrollees shall have documents and materials from the managed care entity provided in printed form. For purposes of this section, "managed care entity" includes, but is not limited to, a

health maintenance organization, preferred provider organization, point of service organization, and any other managed health care delivery entity of any type or description.

376.1575. 1. There is hereby established the "Advisory Commission on Health Insurance Mandates" which shall advise and make recommendations to the general assembly regarding mandated health insurance benefits. The commission shall serve only in an advisory capacity to the general assembly and any recommendations made by such body shall not be binding upon the general assembly. The commission shall be composed of the following members:

(1) The chairperson of the house of representatives which would handle insurance issues;

(2) The chairperson of the committee of the senate which would handle insurance issues;

(3) One member who is an employer or an officer of an employer who employs more than one hundred employees, and who pays a portion of the employees' health insurance premiums, to be appointed by the governor with the advice and consent of the senate;

(4) One member who is an employer or an officer of an employer who employs fewer than one hundred employees, and who pays a portion of the employees' health insurance premiums, to be appointed by the governor with the advice and consent of the senate;

(5) Two individual purchasers of health insurance policies appointed by the governor with the advice and consent of the senate; and

(6) Two employees that pay a portion of their health

insurance sponsored by their employers, appointed by the governor with the advice and consent of the senate.

2. The members of the commission shall elect a chairperson to serve a term of not longer than one year. Members appointed by the governor shall serve for four-year terms and until their successors are appointed. Provided, however, that the terms of half of the six original appointees shall be for two years. The members appointed by the governor shall be residents of Missouri. Any vacancy on the commission shall be filled in the same manner as the original appointment.

3. The commission shall conduct one or more meetings during each legislative session to receive inquiries, comments and suggestions from members of the general assembly, and shall conduct a mandated health benefit analysis and make one or more reports to the house of representatives and the senate concerning:

(1) The benefit and costs of each health insurance mandated benefit proposal and each offer of a health insurance benefit proposed during each session of the legislature;

(2) The benefits and cost of each health insurance mandated benefit and each offer of a mandated health insurance benefit currently a part of state law;

(3) Appropriate method or methods of determining the benefits and costs of possible future mandated health insurance benefits and mandated offers of health insurance benefits; and

(4) Such other matters as the commission may deem necessary or proper to analyze the benefits and costs of mandated health insurance benefits and mandated offers of health insurance

benefits.

4. The members of the commission shall serve without compensation in addition to their official compensation, but shall be reimbursed for actual and necessary expenses incurred in the performance of their official duties. Reimbursement for actual and necessary expenses incurred in the performance of the commission's official duties shall be provided by the director of the department of insurance from funds appropriated for such purpose. The department of insurance shall provide such support as the commission requires to aid it in the performance of its duties. Subject to appropriation, the commission may hire a health insurance actuary to assist the commission in its duties.

5. For purposes of this section, the term "mandated health insurance benefit" shall mean coverage or offering required by law to be provided by a health carrier to:

(1) Cover a specific health care service or services;

(2) Cover treatment of a specific condition or conditions; or

(3) Contract, pay, or reimburse specific categories of health care providers for specific services; a mandated option is not a mandated health benefit.

6. The commission shall be established by October 1, 2002.

Section 1. The department of social services, division of medical services, shall, prior to January 15, 2003, study the development of a preferred drug list, the use of a pharmacy benefit manager (PBM), drug manufacturers rebates, prior authorization of new drugs, pharmacy dispensing fees and drug ingredient cost reimbursement within the Medicaid program. Such

study shall consider the impact on patients, direct and indirect costs, and anticipated savings of each proposal. The department of social services, division of medical services, shall prepare a report of the findings of the study to the governor, members of the senate appropriations committee, the senate public health and welfare committee and the house budget committee.